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Abstracts

Geographic disparities in care and outcomes for noncurative pancreatic adenocarcinoma: a population-based study. ***Elliott Yee, MD(c); Natalie Coburn, MD MPH; Laura Davis, MSc; Alyson Mahar, PhD; Ying Liu, MSc; Julie Hallet, MD MSc.*** **From the Faculty of Medicine, University of Toronto, Toronto, Ont. (Yee); the Sunnybrook Research Institute, Toronto, Ont. (Yee, Coburn, Davis, Hallet); the Odette Cancer Centre — Sunnybrook Health Sciences Centre, Toronto, Ont. (Coburn, Hallet); ICES, Toronto, Ont. (Coburn, Liu); and the Department of Community Health Sciences, University of Manitoba, Winnipeg, Man. (Mahar).**

Background: Noncurative pancreatic adenocarcinoma (PA) portends a guarded prognosis. Advancements in systemic therapy have improved this outlook, but little is known about whether patients access therapies and how it affects outcomes. We examined geographic distribution of provision of care and outcomes for noncurative PA across Ontario. **Methods:** We conducted a population-based analysis of nonresected PA from 2005 to 2017 by linking administrative health care data sets. Outcomes were medical oncology consultation; care by high-volume medical oncology provider (≥ 16 patients/yr/provider); cancer-directed therapy (CDT), defined as chemotherapy or chemoradiation; and overall survival. Geographic information system analysis was used to map outcomes across census divisions, including display of cancer care centres by care level. **Results:** Of 15 970 patients surviving a median of 3.3 months (interquartile range [IQR] 1.2–8.6), 38.5% received CDT. A total of 65.6% of patients had medical oncology consultation, including 45.2% of those not receiving CDT. High-volume medical oncologists cared for 17.1% of patients. Regions of comparable overall survival and use of care were clustered throughout Ontario. Cancer care centres were distributed unevenly, with higher-level centres clustered in Southern Ontario. Higher-level care centres were clustered in regions with higher rates of consultation, CDT and survival. **Conclusion:** The majority of patients with noncurative PA did not receive CDT. Of those, more than half did not see medical oncology. Care delivery and survival exhibited high geographic variability. Proximity to cancer care centres influenced differences in outcomes, suggesting inequitable provision of care across the jurisdiction. This information is important to design strategies and pathways to optimize access and delivery of care, and improve PA outcomes.

Clinical outcomes of atypical lipomatous tumours/well-differentiated liposarcoma of the extremities and trunk wall undergoing marginal versus wide excision: a systematic review of the literature. ***Kyoo-Yoon Choi, MD; Lloyd Mack, MD; Antoine Bouchard-Fortier, MD.*** **From the Department of Surgery, University of Calgary, Calgary, Alta. (Choi, Mack, Bouchard-Fortier).**

Background: Atypical lipomatous tumours (ALT) or well-differentiated liposarcomas (WDLS) that arise in the chest wall and extremities have a relatively benign clinical course. Reported data on clinical outcomes, including local recurrence, vary, and there is no consensus on the best surgical approach for ALT/WDLS of the extremities and trunk wall. This study aims to compare clinical outcomes of patients with these tumours undergoing marginal versus wide excision through a systematic review of the available evidence. **Methods:** A systematic review was performed of articles from Medline, EMBASE, and Scopus for all studies reporting clinical outcomes of patients with ATL/WDLS on the extremities and trunk wall undergoing marginal or wide excision between 1946 and November 2018. **Results:** Nineteen studies with a total of 793 patients were included. Of these, 580 patients underwent marginal excision, with local recurrence in 68 patients (11.7%), and 213 patients underwent wide excision, with local recurrence in 7 patients (3.3%). Dedifferentiation was confirmed in 9 patients (1.1%), and distant metastasis was confirmed in 1 patient (0.1%). **Conclusion:** Marginal excision of ATL/WDLS of the extremities and trunk wall results in higher local recurrence than wide excision. However, the clinical course of these tumours is relatively benign, with re-recurring tumours mostly amenable to re-resection. This study supports the use of marginal excision as a first approach for ATL/WDLS.

Gaps in the management of depression symptoms following cancer diagnosis: a population-based analysis of prospective patient-reported outcomes. ***Julie Hallet, MD MSc; Laura E. Davis, MSc; Elie Isenberg-Grzeda, MD; Alyson L. Mahar, PhD; Haoyu Zhao, MPH; Victoria Zuk, MSc; Lesley Moody, PhD(c); Natalie G. Coburn, MD MPH.*** **From the Odette Cancer Centre — Sunnybrook Health Sciences Centre, Toronto, Ont. (Hallet, Isenberg-Grzeda, Coburn); Sunnybrook Research Institute, Toronto, Ont. (Hallet, Davis, Zuk, Coburn); ICES, Toronto, Ont. (Zhao, Coburn); Department of Community Health Sciences, University of Manitoba, Winnipeg, Man. (Mahar); and Cancer Care Ontario, Toronto, Ont. (Moody).**

Background: Routine screening for depression symptoms is recommended for patients with cancer, but whether screening facilitates access to psychosocial interventions and addresses symptoms remains unclear. We examined the use of psychosocial interventions for patient-reported depression symptoms following cancer diagnosis. **Methods:** We conducted a population-based study of incident adult cancers diagnosed from 2010 to 2017 with at least 1 Edmonton Symptom Assessment System (ESAS) assessment. Depression symptoms were considered to be present in those with an ESAS score ≥ 2 out of 10 for the depression item within 6 months of cancer diagnosis. Outcomes were psychosocial interventions around the time of depression symptoms: palliative care assessment, psychiatry/psychology assessment, social work referral, and antidepressant therapy (in patients ≥ 65 yr who had universal drug coverage). We examined reduction in depression symptoms (≥ 1 point) following intervention. Modified Poisson regression was used to examine factors associated with each intervention. **Results:** Of 142 270 patients, 46.0% reported depression symptoms at a median of 66 days (interquartile range 34–105) postdiagnosis. Of those, 17.1% received palliative assessment, 1.7% psychiatry/psychology assessment, 8.4% social work referral, and 4.3% antidepressant therapy. Depression symptoms decreased in 67.2% with palliative assessment, 63.7% with psychiatry/psychology assessment, 67.3% with social work referral, and 71.4% with antidepressant therapy. Patients with older age, rural residence, lowest income quintile, and genitourinary or oropharyngeal cancer were more likely to not receive intervention. **Conclusion:** The proportion of patients reporting depression symptoms after cancer diagnosis who received psychosocial intervention is worrisomely low. We identified patients more vulnerable to not receiving psychosocial interventions who may benefit from additional support.

These data represent a call to action to modify current practices and optimize the usefulness of systematic symptom screening.

The use of sentinel lymph node biopsy in the management of cutaneous melanoma in the province of British Columbia. ***Sita O. Ollek, MD; Stephanie L. Minkova; Kadhim M. Taqi, MD; Magdalena Martinka, MD; Noelle L. Davis, MD; Andrew McFadden, MD; Andrea J. MacNeill, MD MSc; Trevor D. Hamilton, MD MSc; Heather C. Stuart, MD MSc.*** **From the Division of General Surgery, Vancouver General Hospital, Vancouver, BC (Ollek, Minkova, Taqi, Davis, McFadden, MacNeil, Hamilton, Stuart); and the Division of Anatomic Pathology, Vancouver General Hospital, Vancouver, BC (Martinka).**

Background: Sentinel lymph node biopsy (SLNB) for melanoma plays a central role in determining prognosis and guiding treatment and surveillance strategies. The National Comprehensive Cancer Network (NCCN) guideline recommends the use of SLNB in select patients. The aim of this study was to determine the frequency of SLNB performed in patients with melanoma in British Columbia (BC). **Methods:** A retrospective review was performed of patients diagnosed with clinically node-negative melanoma between January 2016 and December 2017 at a tertiary referral centre in BC. Patients with a Breslow depth > 0.75 mm and ≤ 0.75 mm in the presence of ulceration or a mitotic rate of ≥ 1/mm^2 were included. Primary tumour characteristics and operative procedures were collected, and the frequency of SLNB was determined. SLNB was considered to be indicated in any patient with clinical stage IB–IIC disease. **Results:** We included 528 patients with a median age at diagnosis of 69 years. Using the American Joint Committee on Cancer (AJCC) 7th edition staging, the distribution of clinical stage at presentation for stages IA, IB and II was 12%, 44% and 44%, respectively. Overall, 88% (463) of patients had an indication for SLNB, while only 49% (257) of patients underwent SLNB. The SLNB was positive in 16.7% of patients. Using the AJCC 8th edition staging, the proportion of patients with an indication for SLNB rose to 99%. **Conclusion:** Variation exists in the frequency of SLNB. Appropriate staging is imperative to guide treatment and optimize outcomes. With the evolving field of adjuvant systemic treatment options, accurate staging is particularly relevant today.

Gastric cancer in elderly patients: treatment usage and outcomes in patients older than 75 years. ***Evan Jost, MD; Lloyd Mack, MD; Michael McCall, MD; Antoine Bouchard-Fortier, MD MSc.*** **From the University of Calgary Department of Surgical Oncology, Tom Baker Cancer Centre, Edmonton, Alta. (Jost, Mack, Bouchard-Fortier); and the University of Alberta Department of Surgical Oncology, Royal Alexandra Hospital, Edmonton, Alta. (McCall).**

Background: As Canada's population ages, incidence of gastric cancer in elderly patients is increasing. There are little data on treatment and outcomes of gastric cancer in patients older than 75 years. This study aimed to assess treatment patterns and outcomes of elderly patients with nonmetastatic gastric cancer in Calgary, Alta. **Methods:** Records of elderly (age > 75 yr) patients diagnosed in Calgary with localized gastric cancer between 2007 and 2012 were retrospectively collected from the Alberta Cancer Registry. A chart review was completed to gather demographics; treatment details of surgery, chemotherapy and radiotherapy; and outcomes. Descriptive analyses were undertaken, and variables were compared with parametric and nonparametric tests where appropriate. **Results:** Sixty-two patients (65% male, median age 80 [range 75–96] yr) were included. Forty-six had curative intent surgery, with 44 (96%) achieving described R0 resection. Forty-five (94%) had negative margins on final pathology. A mean of 13 lymph nodes (range 0–36) were retrieved. Twenty-eight surgical patients (58%) had grade III or higher complications, with 3 (6%) perioperative deaths. One (2%) patient completed perioperative chemotherapy, and 3 (6%) patients had adjuvant chemo/radiotherapy (2/3 completed). Fifteen (31%) recurred at a median of 81 months. Median overall survival in operative patients was 40 ± 26.3 months versus 28 ± 25.9 months for the entire cohort. **Conclusion:** Our findings suggest that even with surgery alone, select elderly patients with nonmetastatic gastric cancer can obtain apparent prolonged survival, despite not receiving standard of care multimodality therapy. More studies are needed to optimize elderly patients' treatment selection.

Clinician under-recognition of symptom severity in patients with retroperitoneal sarcoma: a comparison of physician assessments and patient self-reported outcomes. ***Andrea M. Covelli, MD PhD; Deanna Ng, MBBS; Sally Burtenshaw, MSc; Rebecca Gladdy, MD PhD; Savtai Brar, MD; Carol Swallow, MD PhD.*** **From the Department of Surgical Oncology, University of Toronto, Toronto, Ont. (Covelli); the Department of Surgical Oncology, Princess Margaret Cancer Centre, Toronto, Ont. (Ng, Burtenshaw, Gladdy, Swallow); and the Department of Surgical Oncology, Mount Sinai Hospital, Toronto, Ont. (Brar).**

Background: Patients with retroperitoneal sarcoma (RPS) may experience a substantial symptom burden. In recognition of symptom burden, patient-reported measures such as the Edmonton Symptom Assessment System (ESAS) have been developed. The ESAS is purported to identify otherwise unrecognized symptoms. It is unclear whether patients with resected RPS have unrecognized symptoms. We investigated the correlation between patients' self-reported symptoms and those documented by the health care team. **Methods:** A single-institute, retrospective chart review was performed for all patients with primary RPS resected between January 2014 and December 2016. ESAS scores for pain, tiredness, depression (categorized by severity: none, mild, moderate, severe), and preoperative and 1-year postoperative Eastern Cooperative Oncology Group (ECOG) scores were collected. Two researchers independently coded clinician notes for patients' symptoms and severity. **Results:** Fifty-three patients met the inclusion criteria. Median age was 61 years, and 47% were female. Median tumour size was 17.6 cm. There was high correlation (93%–100%) between clinician documentation of symptoms of pain, tiredness and depression with no or mild ESAS scores. As symptom severity increased, correlation between ESAS scores and clinician reports decreased, with a correlation of 0%–50% for moderate symptoms and 0%–33% for severe symptoms. Correlation of moderate and severe symptoms was highest for pain (20%–50%) and lowest for depression (0%–17%). There was only moderate correlation between patient-reported and clinician-identified ECOG scores. There was no mention of patient-reported moderate or severe symptoms in the clinician notes 42% of the time. **Conclusion:** Goals of ESAS are to facilitate recognition of symptom-related needs and to improve patient care. The impact of RPS and its treatment on quality of life may be underrecognized and undertreated by practising clinicians.